

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0038000</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>ALDEN TOWN MANOR REHAB & HCC</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>60120 W. Ogden</u> <u>Cicero</u> <u>60605</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Steven M. Kroll</u> (Title) <u>Chief Financial Officer</u>	
Telephone Number: <u>(773) 286-3883</u> Fax # <u>(773) 286-3743</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>	
IDPA ID Number: <u>36-3695814</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>09/16/92</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 286-3883</u>			

STATE OF ILLINOIS

Page 2

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC# 0038000 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>249</u>	Skilled (SNF)		<u>90,885</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>249</u>	TOTALS		<u>90,885</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,738</u>	<u>2,570</u>	<u>5,027</u>	<u>10,335</u>	8
9	SNF/PED					9
10	ICF	<u>50,163</u>	<u>6,948</u>	<u>1,077</u>	<u>58,188</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>52,901</u>	<u>9,518</u>	<u>6,104</u>	<u>68,523</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 75.40%

D. How many bed-hold days during this year were paid by Public Aid?

none (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 6/15/93

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/1/92 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 60 and days of care provided 4,628Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	376,006	45,214	6,000	427,220	961	428,181		428,181		1
2	Food Purchase		438,893		438,893	(43,473)	395,420	(17,467)	377,953		2
3	Housekeeping	181,457	27,188		208,645	1,617	210,262		210,262		3
4	Laundry	67,791	16,824		84,615	166	84,781		84,781		4
5	Heat and Other Utilities			230,407	230,407		230,407	(3,566)	226,841		5
6	Maintenance	62,056	101	136,369	198,526	10,666	209,192	18,949	228,141		6
7	Other (specify):*										7
8	TOTAL General Services	687,310	528,220	372,776	1,588,306	(30,063)	1,558,243	(2,084)	1,556,159		8
	B. Health Care and Programs										
9	Medical Director			110,448	110,448		110,448		110,448		9
10	Nursing and Medical Records	2,743,003	185,752	5,976	2,934,731	7,056	2,941,787	(30,426)	2,911,361		10
10a	Therapy	61,007			61,007		61,007		61,007		10a
11	Activities	57,240	5,357	6,044	68,641	1,675	70,316		70,316		11
12	Social Services	45,461			45,461		45,461		45,461		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,906,711	191,109	122,468	3,220,288	8,731	3,229,019	(30,426)	3,198,593		16
	C. General Administration										
17	Administrative	179,684			179,684		179,684		179,684		17
18	Directors Fees										18
19	Professional Services			863,416	863,416	(10,000)	853,416	(733,726)	119,690		19
20	Dues, Fees, Subscriptions & Promotions			47,084	47,084	(408)	46,676	(33,577)	13,099		20
21	Clerical & General Office Expenses	569,410	16,754	(11,724)	574,440	1,245	575,685	41,418	617,103		21
22	Employee Benefits & Payroll Taxes			561,774	561,774	31,088	592,862	76,468	669,330		22
23	Inservice Training & Education										23
24	Travel and Seminar			3,460	3,460		3,460	15,002	18,462		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			56,681	56,681		56,681	5,898	62,579		26
27	Other (specify):* Bad Debt			295,644	295,644		295,644	(295,644)			27
28	TOTAL General Administration	749,094	16,754	1,816,335	2,582,183	21,925	2,604,108	(924,161)	1,679,947		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,343,115	736,083	2,311,579	7,390,777	593	7,391,370	(956,671)	6,434,699		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC

#0038000

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation					68,275	68,275	359,864	428,139			30
31	Amortization of Pre-Op. & Org.			9,356	9,356		9,356	878,796	888,152			31
32	Interest			133,234	133,234		133,234	1,480,000	1,613,234			32
33	Real Estate Taxes			11,522	11,522	10,000	21,522	759,982	781,504			33
34	Rent-Facility & Grounds			2,032,540	2,032,540		2,032,540	(2,031,751)	789			34
35	Rent-Equipment & Vehicles			8,600	8,600		8,600	22,321	30,921			35
36	Other (specify):* Mortg. Insurance			78,868	78,868	(78,868)		63,160	63,160			36
37	TOTAL Ownership			2,274,120	2,274,120	(593)	2,273,527	1,532,372	3,805,899			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		284,623	327,910	612,533		612,533	(189,992)	422,541			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		116		116		116	(116)	(0)			41
42	Provider Participation Fee			136,328	136,328		136,328		136,328			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		284,739	464,238	748,977		748,977	(190,108)	558,869			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,343,115	1,020,822	5,049,937	10,413,874		10,413,874	385,592	10,799,466			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC

0038000

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	14,451	30		9
10 Interest and Other Investment Income	(828)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(3,312)	2		13
14 Non-Care Related Interest	(64,956)	32		14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(2,774)	32		18
19 Entertainment	(795)	20		19
20 Contributions	(800)	20		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(295,644)	27		24
25 Fund Raising, Advertising and Promotional	(26,142)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(550)	20		28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (381,350)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	824,794		34
35 Other- Attach Schedule	(57,852)	pg 5a	35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 766,942		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 385,592		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39		x			39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

ALDEN TOWN MANOR REHAB & HCC

ID# 0038000

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	BACK OUT: HEALTHCARE ASSOC PAC FEES	\$ (1,102)	20	1
2	BACK OUT:CLOTHING /GIFT SHOP ITEMS	(116)	41	2
3	LEGAL FEES-COLLECTIONS	(13,050)	21	3
4	BACK OUT MARKETING MGT FEE	(1,631)	20	4
5	BACK OUT MARKETING CONSULTANT	(3,060)	20	5
6	Record add'l def maint exp to correct amt.	3,222	6	6
7	Back out utility late fee	(3,566)	5	7
8	offset miscell income due to insurance adj	(6,477)	26	8
9	Back out ytd interco interest in gl 7053	(23,302)	32	9
10	back out marketing salary	(8,768)	21	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(57,852)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC

0038000

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,312)	0	0	(14,155)	0	0	0	0	0	0	0	(17,467)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,566)	0	0	0	0	0	0	0	0	0	0	(3,566)	5
6	Maintenance	3,222	0	15,742	0	0	0	(15)	0	0	0	0	18,949	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,656)	0	15,742	(14,155)	0	0	(15)	0	0	0	0	(2,084)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(29,456)	(970)	0	0	0	0	0	0	(30,426)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	(29,456)	(970)	0	0	0	0	0	0	(30,426)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	22,071	(755,797)	0	0	0	0	0	0	0	0	(733,726)	19
20	Fees, Subscriptions & Promotions	(34,081)	0	504	0	0	0	0	0	0	0	0	(33,577)	20
21	Clerical & General Office Expenses	(21,818)	0	31,296	25,597	6,343	0	0	0	0	0	0	41,418	21
22	Employee Benefits & Payroll Taxes	0	0	75,459	0	1,009	0	0	0	0	0	0	76,468	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	15,002	0	0	0	0	0	0	0	0	15,002	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(6,477)	12,375	0	0	0	0	0	0	0	0	0	5,898	26
27	Other (specify):*	(295,644)	0	0	0	0	0	0	0	0	0	0	(295,644)	27
28	TOTAL General Administration	(358,020)	34,446	(633,536)	25,597	7,352	0	0	0	0	0	0	(924,161)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(361,676)	34,446	(617,794)	(18,014)	6,382	0	(15)	0	0	0	0	(956,671)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **ALDEN TOWN MANOR REHAB & HCC** # **0038000** Report Period Beginning: **01/01/2002** Ending: **12/31/2002**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	14,451	331,509	12,564	0	1,340	0	0	0	0	0	0	359,864 30
31	Amortization of Pre-Op. & Org.	0	876,872	1,878	0	0	46	0	0	0	0	0	878,796 31
32	Interest	(91,860)	1,511,588	58,577	0	1,056	639	0	0	0	0	0	1,480,000 32
33	Real Estate Taxes	0	754,626	5,029	0	327	0	0	0	0	0	0	759,982 33
34	Rent-Facility & Grounds	0	(2,032,540)	789	0	0	0	0	0	0	0	0	(2,031,751) 34
35	Rent-Equipment & Vehicles	0	0	22,321	0	0	0	0	0	0	0	0	22,321 35
36	Other (specify):*	0	63,160	0	0	0	0	0	0	0	0	0	63,160 36
37	TOTAL Ownership	(77,409)	1,505,215	101,158	0	2,723	685	0	0	0	0	0	1,532,372 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(18,885)	(41,462)	(129,645)	0	0	0	0	0	(189,992) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	(116)	0	0	0	0	0	0	0	0	0	0	(116) 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	(116)	0	0	(18,885)	(41,462)	(129,645)	0	0	0	0	0	(190,108) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(439,202)	1,539,661	(516,636)	(36,899)	(32,357)	(128,960)	(15)	0	0	0	0	385,592 45

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC# 0038000Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc.	100	See page 6k		See page 6k		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent income	\$ 2,032,540	Cicero Associates Limited Partnership		\$	\$ (2,032,540) 1
2	V	32 Investment income -RR	7,154	Cicero Associates Limited Partnership			(7,154) 2
3	V	33 Real estate taxes		Cicero Associates Limited Partnership		754,626	754,626 3
4	V	26 Property & liability insurance		Cicero Associates Limited Partnership		12,375	12,375 4
5	V	32 Interest on mortgage payable		Cicero Associates Limited Partnership		790,500	790,500 5
6	V	32 Interest on operating loss loan		Cicero Associates Limited Partnership		156,045	156,045 6
7	V	36 Mortgage insurance premium		Cicero Associates Limited Partnership		63,160	63,160 7
8	V	19 Misc. financial expense		Cicero Associates Limited Partnership		22,071	22,071 8
9	V	32 Prepayment penalty on debt		Cicero Associates Limited Partnership		572,197	572,197 9
10	V	30 Depreciation		Cicero Associates Limited Partnership		331,509	331,509 10
11	V	31 Amortization		Cicero Associates Limited Partnership		876,872	876,872 11
12	V						
13	V						
14	Total		\$ 2,039,694			\$ 3,579,355	\$ * 1,539,661 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC# 0038000Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Benefits	\$	Alden Management Services, Inc.	0.00%	\$ 75,459	\$ 75,459	15
16	V	19 Management fees	769,612	Alden Management Services, Inc.		13,815	(755,797)	16
17	V	21 Gen'l & Admin.		Alden Management Services, Inc.		31,296	31,296	17
18	V	6 maintenance/utilities		Alden Management Services, Inc.		4,296	4,296	18
19	V	6 maintenance		Alden Management Services, Inc.		11,446	11,446	19
20	V	24 autos/seminars		Alden Management Services, Inc.		15,002	15,002	20
21	V	20 dues/subscriptions		Alden Management Services, Inc.		504	504	21
22	V	30 depreciation		Alden Management Services, Inc.		12,564	12,564	22
23	V	31 amortization		Alden Management Services, Inc.		1,878	1,878	23
24	V	33 real estate tax		Alden Management Services, Inc.		5,029	5,029	24
25	V	34 rent		Alden Management Services, Inc.		789	789	25
26	V	35 rent-equip/vehicles		Alden Management Services, Inc.		22,321	22,321	26
27	V	32 interest		Alden Management Services, Inc.		58,577	58,577	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 769,612			\$ 252,976	\$ * (516,636)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC# 0038000Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 Tube feeding	\$ 38,186	Pyramid Health Care Services	100.00%	\$ 24,031	\$ (14,155)	15
16	V	10 Nursing supply	37,052	Pyramid Health Care Services		7,596	(29,456)	16
17	V	39 Per diem/other supplies	46,060	Pyramid Health Care Services		27,175	(18,885)	17
18	V	21 General & admin		Pyramid Health Care Services		25,597	25,597	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 121,298			\$ 84,399	\$ * (36,899)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC# 0038000Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Drugs	\$ 92,833	Foum Extended Care II	100.00%	\$ 71,169	\$ (21,664)	15
16	V	10 House stock	4,156	Foum Extended Care II		3,186	(970)	16
17	V	39 IV	84,839	Foum Extended Care II		65,041	(19,798)	17
18	V	22 Emkplyee benefits		Foum Extended Care II		1,009	1,009	18
19	V	21 G & A		Foum Extended Care II		6,343	6,343	19
20	V	32 Interest		Foum Extended Care II		1,056	1,056	20
21	V	33 Real estate taxes		Foum Extended Care II		327	327	21
22	V	30 Deprectiaon		Foum Extended Care II		1,340	1,340	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 181,828			\$ 149,471	\$ * (32,357)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC# 0038000Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 Therapy	\$ 358,840	Community Physical Therapy	100.00%	\$ 229,195	\$ (129,645)
16	V	32 Interest		Community Physical Therapy		639	639
17	V	31 Amortization		Community Physical Therapy		46	46
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 358,840			\$ 229,880	\$ * (128,960)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC# 0038000Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	6 maintenance expense	\$ 4,973	Alden Bennett Construction	100.00%	\$ 4,958	\$ (15)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 4,973			\$ 4,958	\$ *	(15) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	Chief Executive		339,193	0.2644	6.61	SALARY	\$ 24,019	17-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin.		85,647	0.2644	6.61	SALARY	6,065	17-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/mainten		80,141	0.2644	6.61	SALARY	5,675	17-1	3
4	Joan Carl d.	Secretary	Vice-President		206,468	0.2644	6.61	SALARY	14,620	17-1	4
5											5
6											6
7	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										7
8	b. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										8
9	c. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										9
10	d. Joan Carl is the Secretary of Alden Management Services and all nursing facilities. She has an equity interest in Town Manor, Princeton, Valley Ridge,										10
11	North Shore, Orland Park, and Waterford. She has an equity interest in the real estate of Alma Nelson, Park Strathmoor, and Meadow Park.										11
12											12
13								TOTAL	\$ 50,379		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC # 0038000 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.
 Street Address 4200 W. Peterson Ave.
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 286-3883
 Fax Number (773) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	see page 8A (also on page 6A)				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Cambridge Healthcare		X	Mortgage	\$58,982.00	11/2002	\$ 10,617,600	\$	paid off	5.7800	\$ 780,412	1	
2	Cambridge Healthcare		x	mortgage	\$58,985.00	1/2003	10,617,600	10,617,600	12/2037	5.7800	10,088	2	
3	prepayment interest on old loans		X								572,197	3	
4	Prudentail		x	operating loss loan	\$15,777.00	9/1/95	2,104,700		paid off	varies	154,017	4	
5	Cambridge Healthcare		x	operating loss loan	\$10,728.00	1/2003	2,104,700		10/2038	5.7800	2,028	5	
	Working Capital												
6	Related party - AMS	X		working capital							58,577	6	
7	Related party - FECII	X		working capital							1,056	7	
8	Related party - CPT/CORUS/b	X		working capital							42,842	8	
9	TOTAL Facility Related				\$144,472.00		\$ 25,444,600	\$ 10,617,600			\$ 1,621,217	9	
	B. Non-Facility Related*												
10	offset interest expense with Cic Assoc interest income on Repl. Resrv'										(7,154)	10	
11	offset interest expense with Corp's. interest income on patient accounts										(829)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (7,983)	14	
15	TOTALS (line 9+line14)						\$ 25,444,600	\$ 10,617,600			\$ 1,613,234	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 63,160 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **ALDEN TOWN MANOR REHAB & HCC**# **0038000** Report Period Beginning: **01/01/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$ 698,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 727,148	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 29,148	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 737,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ 10,000	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 776,148	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997 490,544	8	
	1998 527,775	9	
	1999 614,479	10	
	2000 677,830	11	
	2001 715626.36*	12	
Accrual based on 3% increase over prior year bill.			
\$715,626.36 X 1.03 = 737,000 plus, an additional estimate due for parking lot (see page RE_Tax (3))		13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
* An additional amount of \$11,522.50 was due for parking lot (see page RE_Tax (3))		14	PLUS APPEAL COST FROM LINE 5 \$ 14
		15	LESS REFUND FROM LINE 6 \$ 15
		16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALDEN TOWN MANOR REHAB & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038000

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-32-115-017-0000</u>	<u>Nursing home facility</u>	\$ <u>1,613.85</u>	\$ <u>1,613.85</u>
2. <u>13-32-115-018-0000</u>	<u>Nursing home facility</u>	\$ <u>1,613.85</u>	\$ <u>1,613.85</u>
3. <u>13-32-115-019-0000</u>	<u>Nursing home facility</u>	\$ <u>59,480.81</u>	\$ <u>59,480.81</u>
4. <u>13-32-115-020-0000</u>	<u>Nursing home facility</u>	\$ <u>83,005.17</u>	\$ <u>83,005.17</u>
5. <u>13-32-115-026-0000</u>	<u>Nursing home facility</u>	\$ <u>308,591.24</u>	\$ <u>308,591.24</u>
6. <u>16-32-116-020-000</u>	<u>Nursing home facility</u>	\$ <u>138,599.79</u>	\$ <u>138,599.79</u>
7. <u>16-32-116-021-000</u>	<u>Nursing home facility</u>	\$ <u>58,160.56</u>	\$ <u>58,160.56</u>
8. <u>16-32-116-022-000</u>	<u>Nursing home facility</u>	\$ <u>58,671.17</u>	\$ <u>58,671.17</u>
9. <u>16-32-116-023-000</u>	<u>Nursing home facility</u>	\$ <u>2,983.39</u>	\$ <u>2,983.39</u>
10. <u>16-32-116-024-000</u>	<u>Nursing home facility</u>	\$ <u>2,906.53</u>	\$ <u>2,906.53</u>
	TOTALS	\$ <u><u>715,626.36</u></u>	\$ <u><u>715,626.36</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALDEN TOWN MANOR REHAB & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038000

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-3883 FAX #: 773-286-3743

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-32-116-006-000</u>	<u>Nursing home facility</u>	\$ <u>1,365.74</u>	\$ <u>1,365.74</u>
2. <u>16-32-116-007-000</u>	<u>Nursing home facility</u>	\$ <u>982.11</u>	\$ <u>982.11</u>
3. <u>16-32-116-008-000</u>	<u>Nursing home facility</u>	\$ <u>1,931.89</u>	\$ <u>1,931.89</u>
4. <u>16-32-116-009-000</u>	<u>Nursing home facility</u>	\$ <u>2,787.30</u>	\$ <u>2,787.30</u>
5. <u>16-32-116-010-000</u>	<u>Nursing home facility</u>	\$ <u>2,587.80</u>	\$ <u>2,587.80</u>
6. <u>16-32-116-011-000</u>	<u>Nursing home facility</u>	\$ <u>1,867.66</u>	\$ <u>1,867.66</u>
7. _____	<u>Related Party - Alden Management</u>	\$ <u>76,052.00</u>	\$ <u>5,029.00</u>
8. _____	<u>Related Party - Forum</u>	\$ <u>8,608.00</u>	\$ <u>327.00</u>
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>96,182.50</u></u>	\$ <u><u>16,878.50</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

94,195

B. General Construction Type:

Exterior

brick

Frame

steel

Number of Stories

3

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing home	66,775	1991	\$ 1,137,260	1
2					2
3	TOTALS	66,775		\$ 1,137,260	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	related party -- forum			1978	\$ 18,359	\$	22	\$	\$	\$ 18,359	4
5											5
6	249		1992	1992	9,104,204	289,022	30	303,473	14,451	2,331,663	6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC

0038000

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Window glass repair	1992	\$ 1,600	\$ 93	10	\$ 93	\$	\$ 1,600		37
38	CSI - boiler repair	1994	3,268		3			3,268		38
39	Tower cleaners - drapery	1995	1,557		5			1,557		39
40	Bartlett heating -pipe insulation	1995	3,700	247	15	247		1,809		40
41	CSI - a/c repair	1995	4,093	409	10	409		3,035		41
42	CSI - a/c repair	1995	4,027	403	10	403		2,986		42
43	CSI - pipe insulation	1995	1,981	132	15	132		1,012		43
44	CSI - chiller HVAC	1996	6,042	604	10	604		3,978		44
45	The floor source - carpet installation	1996	5,345	534	10	534		3,563		45
46	Ward door specialist, Inc. - metal door	1996	1,385	92	15	92		600		46
47	Shalom landscaping - planting	1996	8,000	800	10	800		5,733		47
48	The floor source - carpet installation	1996	6,049	605	10	605		3,831		48
49	Bartlett heating -pipe insulation	1996	18,526	1,236	15	1,236		9,057		49
50	Over charged by Bartlett	1996	(10,500)	(1,400)		(1,400)		(7,082)		50
51	Alden Bennett const. - heating, vent , a/c	1996	69,300	3,465	20	3,465		22,234		51
52	Alden Bennett construction - sanitary sewer lift station	1996	23,921	1,196	20	1,196		7,675		52
53	Arrigo enterprises, Inc. - heating and cooling sys. Cooridor	1996	10,931	546	20	546		3,552		53
54	Misco shawnee, Inc. - tile	1996	9,232	462	20	462		2,962		54
55	Misco shawnee, Inc. - tile	1996	9,020	451	20	451		2,894		55
56	General parts - repair dishwasher	1997	2,139	178	5	178		2,139		56
57	Svstem Electric - 120 volt circuit installed and replaced	1997	2,085		5			2,085		57
58	Climate - freon into a/c	1997	6,221	518	5	518		6,221		58
59	Long elevator - install new eyes on elevator door	1997	3,180	159	5	159		3,180		59
60	A&B cable - outlets installation	1997	11,520	1,920	5	1,920		11,520		60
61	Arrigo enterprises, Inc. - corridor renovation	1997	24,366	1,218	20	1,218		7,513		61
62	ABC - hvac repairs	1998	39,300	1,965	20	1,965		9,334		62
63	ABC - sanitary sewer lift station	1998	1,259	63	20	63		299		63
64	Coit drapery	1998	12,976	2,595	5	2,595		12,543		64
65	CSI - replaced fuse and cleaned ice machine	1998	3,267	327	10	327		1,470		65
66	Wigdahl-replace parking lot timeclock and fixtres	1998	3,703	370	10	370		1,636		66
67	CSI - replace diffusers, bower motor	1998	7,571	757	10	757		3,281		67
68	Kraft paper - extractor	1998	2,071	138	15	138		564		68
69	Kraft paper - extractor	1999	10,000	1,000	10	1,000		3,500		69
70	TOTAL (lines 4 thru 69)		\$ 9,429,698	\$ 310,106		\$ 324,557	\$ 14,451	\$ 2,489,572		70

**Improvement type must be detailed in order for the cost report to be considered complete.

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC

0038000

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 9,429,698	\$ 310,106		\$ 324,557	\$ 14,451	\$ 2,489,572	1
2	New horizons - phone system	1999	3,332	333	10	333		1,083	2
3	Advanced parts & services - replace boiler	1999	2,504	125	20	125		459	3
4	Chicago cooling corp - cleaned condensor	1999	1,483	148	10	148		544	4
5	Chicago cooling corp - serviced cond. Water pump	1999	2,230	446	5	446		1,524	5
6	DBS contracting - sprinkler system maint.	1999	1,726	115	15	115		374	6
7	Climater service - repair roooftop exhaust	1999	1,864	186	10	186		590	7
8	Sysem electric - underground pipes, new wires	1999	6,998	350	20	350		1,079	8
9	ABC - excavation work	1999	2,571	257	10	257		857	9
10	Alden design	2000	9,940	994	10	994		2,402	10
11	ABC	2000	8,502	850	10	850		2,409	11
12	Fox valley fire & safety	2000	1,887	189	10	189		519	12
13	Switching sys. - replace ATS	2000	3,343	223	15	223		576	13
14	ABC reverse accruals	2000	(2,571)	(257)	10	(257)		(664)	14
15	Tower cleaner - clean & repair drapes & sheers	2000	3,190	1,063	3	1,063		2,570	15
16	Chicago backflow, Inc - replace backflow valves	2000	1,806	120	15	120		261	16
17	Alden Bennett Const - seal & stripe parking lot	2000	3,109	311	10	311		674	17
18									18
19	Alden Bennett Construction (wall coverings)	2001	15,529	1,553	10	1,553		2,847	19
20	Patten (service elevator)	2001	1,547	77	20	77		155	20
21	Patten (water pump)	2001	2,325	116	20	116		223	21
22	CSI coker services (speed reduction unit)	2001	3,779	378	10	378		693	22
23	DBS contracting - (lawn sprinkler system)	2001	2,121	141	15	141		212	23
24	Simplex time (fire alarm)	2001	3,675	245	15	245		408	24
25	Simplex time (fire pump)	2001	1,800	90	20	90		150	25
26	GT mech (boiler repairs)	2001	4,701	940	5	940		1,880	26
27	CSI coker services (kitchen steamer)	2001	3,037	607	5	607		1,164	27
28	CSI coker services (pump assembly motor)	2001	3,784	378	10	378		694	28
29	The Floor Source (new carpet + labor cost)	2001	13,180	2,636	5	2,636		5,272	29
30	Alden Bennett Construction (time and material billing)	2001	3,177	635	5	635		953	30
31	T&T Irrigation Inc (lawn sprinkler system repairs)	2001	2,120	141	15	141		177	31
32	Alden Bennett Construction (carpet material)	2001	6,636	664	10	664		1,327	32
33	Alden Bennett Construction (repair cabinets and tip in various areas)	2001	6,303	1,261	5	1,261		1,471	33
34	TOTAL (lines 1 thru 33)		\$ 9,555,326	\$ 325,424		\$ 339,874	\$ 14,451	\$ 2,522,454	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,555,326	\$ 325,424		\$ 339,874	\$ 14,451	\$ 2,522,454	1
2	CSI Coker -- (booster heater)	2002	1,616	494	3	494		494	2
3	CSI Coker -- (dishwasher repair)	2002	1,444	321	3	321		321	3
4	Washtown equipment(motor & valve)	2002	1,577	438	3	438		438	4
5	CSI Coker -- (steam table)	2002	528	70	5	70		70	5
6	CSI Coker -- (steamer)	2002	1,325	177	5	177		177	6
7	CSI Coker -- (dishwasher repair)	2002	2,844	119	10	119		119	7
8	GT Mechincal (wheel bower for air unit)	2002	2,662	266	5	266		266	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,567,322	\$ 327,308		\$ 341,759	\$ 14,451	\$ 2,524,339	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 9,567,322	\$ 327,308		\$ 341,759	\$ 14,451	\$ 2,524,339	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	19,335		20			19,335	4
5	Leasehold Improvement-Remodeling	1980	1,208		10			1,208	5
6	Leasehold Improvement-Remodeling	1986	645		5			645	6
7	Leasehold Improvement-Remodeling	1990	404		5			404	7
8	Leasehold Improvement-Remodeling	1991	94		5			94	8
9	Leasehold Improvement-Remodeling	1993	8,304	830	10	830		8,304	9
10	Leasehold Improvement-Remodeling	1993	6,504	469	9.7	469		6,504	10
11	Leasehold Improvement-sign	1994	261	22	12	22		174	11
12	Leasehold Improvement-dryvit	1995	443	44	10	44		310	12
13	Leasehold Improvement-new ac	1999	723	48	15	48		145	13
14	Leasehold Improvement-roof	1985	972	52	19	52		922	14
15	Leasehold Improvement-roof	1994	863	58	15	58		518	15
16	Leasehold Improvement-roof	1997	819	55	15	55		328	16
17	Leasehold Improvement-roof	1998	1,390	93	15	93		464	17
18	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11		33	18
19	Leasehold Improvement-hallway lighting	2001	155	16	10	16		32	19
20	Leasehold Improvement-DAI	2001	195	19	10	19		38	20
21	Leasehold Improvement-bathrooms	2002	687	69	10	69		69	21
22	Leasehold Improvement-Remodeling	2002	98	20	5	20		20	22
23	Related Party-AMS:								23
24	Leasehold Improvement-Remodeling	1993	4,266		7			4,266	24
25	Leasehold Improvement-Remodeling	1994	2,112		7			2,112	25
26	Leasehold Improvement-Remodeling	2002	5,221		7				26
27									27
28									28
29									29
30									30
31									31
32	Related Party-Forum Ext. Care	1999	1,764	241	40	241		183	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 9,623,896	\$ 329,355		\$ 343,806	\$ 14,451	\$ 2,570,447	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,144,779	\$ 66,462	\$ 66,462	\$	VARIOUS	\$ 1,060,046	71
72	Current Year Purchases	44,026	3,438	3,438		VARIOUS	3,438	72
73	Fully Depreciated Assets	96,132	676	676		VARIOUS	96,132	73
74								74
75	TOTALS	\$ 1,284,937	\$ 70,576	\$ 70,576	\$		\$ 1,159,616	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	CAR/ENGINE/BUS/VAN	:DODGE	98-'02	\$ 12,336	\$ 3,792	\$ 3,792	\$	3	\$ 9,992	76
77	bus	01 bus	'01	49,826	9,965	9,965		3	19,930	77
78										78
79										79
80	TOTALS			\$ 62,162	\$ 13,757	\$ 13,757	\$		\$ 29,922	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,108,255	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 413,688	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 428,139	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,451	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,759,985	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$ n/a	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ n/a	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party- cost is backed out.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 8,600 Description: copy machine lease

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Various	Various	\$ 1,860.09	\$ 22,321	17
18					18
19					19
20					20
21	TOTAL		\$ 1,860.09	\$ 22,321	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$

13. /2004 \$

14. /2005 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE _____	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled nurses on site

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 159,888	\$		\$ 159,888	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			21,176			21,176	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			136,978			136,978	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	SEE PAGE 16A	# of prescripts			54,785			54,785	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	SEE PAGE 16A				49,714			49,714	13
14	TOTAL			\$		\$ 422,541	\$		\$ 422,541	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC

0038000

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$ 34,910	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 110,520)	2,095,617	2,095,617	3
4	Supply Inventory (priced at)	1,486	1,486	4
5	Short-Term Investments		801,421	5
6	Prepaid Insurance	6,185	77,404	6
7	Other Prepaid Expenses	2,735	2,735	7
8	Accounts Receivable (owners or related parties)		721,402	8
9	Other(specify): due from IDPA	37,673	37,673	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,143,696	\$ 3,772,648	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		52,816	12
13	Land		1,137,260	13
14	Buildings, at Historical Cost		9,104,204	14
15	Leasehold Improvements, at Historical Cost	544,079	544,079	15
16	Equipment, at Historical Cost	242,457	1,192,372	16
17	Accumulated Depreciation (book methods)	(481,251)	(4,483,156)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe automobiles)	49,826	49,826	22
23	Other(specify): capital lease obligation	392,419	392,419	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 747,531	\$ 7,989,821	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,891,227	\$ 11,762,469	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 407,829	\$ 542,947	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	256,771	256,771	28
29	Short-Term Notes Payable		51,143	29
30	Accrued Salaries Payable	310,138	310,138	30
31	Accrued Taxes Payable (excluding real estate taxes)	52,452	789,452	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	462,977	473,114	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accrued insurance & other expense	24,167	38,248	36
37	due to affiliates	2,693,685	2,693,685	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 4,208,019	\$ 5,155,498	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,231,950	11,752,952	39
40	Mortgage Payable		2,085,552	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,231,950	\$ 13,838,504	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,439,969	\$ 18,994,002	46
47	TOTAL EQUITY (page 18, line 24)	\$ (2,548,742)	\$ (7,231,533)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,891,227	\$ 11,762,469	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,847,896)	1
2	Restatements (describe):		2
3	external audit adjustments made after 2001 cost report was		3
4	submitted. These have no effect on prior years report:	(450,000)	4
5	Bad debt, Medicare revenues (non-allowables)		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,297,896)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(250,846)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (250,846)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,548,742)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,511,979	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,511,979	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	58,433	5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 58,433	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,827	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	1,320	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,147	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	828	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 828	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Other misc. income</u>	5,362	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,362	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,580,749	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,588,306	31
32	Health Care	3,220,288	32
33	General Administration	2,582,183	33
B. Capital Expense			
34	Ownership	2,274,120	34
C. Ancillary Expense			
35	Special Cost Centers	612,649	35
36	Provider Participation Fee	136,328	36
D. Other Expenses (specify):			
37	<u>Related party salary allocations</u>	(582,279)	37
38	<u>included on this page, but included on page 3 & 4.</u>		38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,831,595	40
41	Income before Income Taxes (line 30 minus line 40)**	(250,846)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (250,846)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number ALDEN TOWN MANOR REHAB & HCC# 0038000Report Period Beginning: 01/01/2002Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,775	1,815	\$ 61,548	\$ 33.91	1
2	Assistant Director of Nursing	1,259	1,347	35,349	26.24	2
3	Registered Nurses	26,902	28,492	845,358	29.67	3
4	Licensed Practical Nurses	27,198	28,263	572,095	20.24	4
5	Nurse Aides & Orderlies	86,893	93,628	1,079,659	11.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	664	1,026	13,042	12.71	9
10	Activity Assistants	4,692	4,942	44,199	8.94	10
11	Social Service Workers	1,752	1,872	39,638	21.17	11
12	Dietician					12
13	Food Service Supervisor	1,912	3,317	39,365	11.87	13
14	Head Cook	5,876	5,932	70,227	11.84	14
15	Cook Helpers/Assistants	28,397	32,275	266,414	8.25	15
16	Dishwashers					16
17	Maintenance Workers	1,880	2,000	39,390	19.70	17
18	Housekeepers	19,096	19,328	181,457	9.39	18
19	Laundry	6,704	7,508	67,791	9.03	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	7,081	15,039	164,817	10.96	22
23	Office Manager	308	1,770	5,823	3.29	23
24	Clerical	4,140	4,665	46,933	10.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,256	2,531	59,354	23.45	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Clinical SS	1,510	1,848	38,738	20.96	32
33	Other(specify) <u>ALZHEIMER</u>	7,023	7,823	89,640	11.46	33
34	TOTAL (lines 1 - 33)	237,318	265,421	\$ 3,760,837 *	\$ 14.17	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,000	1-3	35
36	Medical Director	Monthly	20,460	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,976	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	53	2,795	11-3	44
45	Social Service Consultant	11	602	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	64	\$ 35,833		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Fox, J	administrator	0	78,980	Workers' Compensation Insurance	\$	77,666	IDPH License Fee	\$
				Unemployment Compensation Insurance		39,097	Advertising: Employee Recruitment	
				FICA Taxes		286,910	Health Care Worker Background Check	
				Employee Health Insurance		45,273	(Indicate # of checks performed _____)	
				Employee Meals		43,473		
various executives/assist admin	executive admin	0	100,704	Illinois Municipal Retirement Fund (IMRF)*			Surety Bond Fees, Dues & Subscriptions	980
				Related party - FECH		1,009	II. Health Care Assoc.	11,504
				Union Health & Welfare		80,182	Employee Assoc. Dues	111
				Dental, Life and Pension Costs		15,300		
				Relations, Misc., background cks & Tuition		1,616	Related party - AMS	504
				Drug Tests, 401K Match & Vaccinations		3,345	Less: Public Relations Expense	()
				Related party - AMS		75,459	Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)							TOTAL (agree to Sch. V,	\$ 13,099
(List each licensed administrator separately.)			\$ 179,684				line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$				Misc. Gas & Repairs	1,602
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
AMS	Management Fee		769,612				Related party - AMS	15,002
BDO Seidman	Accounting Fees		4,663				Seminar Expense	
Ken Fisch / Greenberg	Legal Fees		25,837				Comprehensive Therapeutics	250
Bob Brusceci & Misc	Consulting Services		4,200				O.C.C. / Life Serv. Network	470
Career Masters	employment fee		13,000				II. Health Care Assoc, Glantz & Other	1,138
Comp. Ther., Medi, Orsini & Other	Professional Fees		2,796				Entertainment Expense	()
Law Offices Of Chicago	Legal Consulting		1,707				(agree to Sch. V,	
Mackelvie & Associates	Medicare appeal		29,361				line 24, col. 8)	\$ 18,462
Schmidt	Prof Fees - Tax Work		10,000					
U S Gas & Energy Corp	Utilities		2,241					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 863,416					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Painting	6/95	\$ 13,250	3	\$	\$	\$	\$	\$	\$	\$	\$	
2	Painting	8/95	678	3									
3	Painting	9/95	740	3									
4	Painting	11/95	1,779	3									
5	Painting	12/95	1,315	3									
6	Painting	1/96	2,669	3									
7	Painting	2/96	1,372	3									
8	Rewiring	2/96	2,276	5									
9	Painting	3/96	1,782	3									
10	Fan	3/96	2,012	15									
11	Painting	4/96	3,472	3									
12	See page 22a	1996	18,923	3-15	2,910	675	675	675	675	675	675	675	
13	See page 22a	1997	9,243	3	3,081	1,477	0						
14	See page 22a	1998	25,643	3	8,548	8,548	4,053	0					
15	See page 22a	1999	11,752	3	1,959	3,917	3,917	1,959					
16	See page 22a	2000	28,466	3		4,821	9,489	9,489	4,668	0			
17	See page 22a	2001	5,082	3			1,371	1,692	1,692	322	0		
18	See page 22a	2002	6,523	3									
19													
20	TOTALS		\$ 136,977		\$ 16,498	\$ 19,438	\$ 19,505	\$ 13,815	\$ 7,035	\$ 997	\$ 675	\$ 675	\$ 675

Facility Name & ID Number ALDEN NURSING CENTER-Town Manor # 0033800 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY99	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Condenser repair	4/96	2,205	10	221	221	221	221	221	221	221	221	221
2	Painting	6/96	1,791	3	249								
3	Air conditioner repair	6/96	2,711	10	271	271	271	271	271	271	271	271	271
4	Air conditioner repair	7/96	2,740	15	183	183	183	183	183	183	183	183	183
5	Painting	7/96	3,445	3	575								
6	Painting	8/96	2,111	3	410								
7	Painting	9/96	1,988	3	441								
8	Painting	11/96	1,104	3	307								
9	Painting	12/96	828	3	253								
10	Total to pg 22, line 12		18,923		2,910	675	675	675	675	675	675	675	675
11	Repair cooler	2/97	1,646	3	549	45							
12	Repair boiler	4/97	3,052	3	1,017	255							
13	Repair leak	8/97	1,550	3	517	301							
14	Repair compressor	11/97	1,414	3	471	393							
15	Repair compressor	12/97	1,581	3	527	483							
16	Total to pg 22, line 13		9,243		3,081	1,477	0						
17	Replace pump motor	2/98	1,719	3	573	573	48	0	0				
18	Replace belts on fans	4/98	2,348	3	783	783	195	0	0				
19	Repair boiler	7/98	2,308	3	769	769	405	0	0				
20	Replace actuator	12/98	1,694	3	565	565	517	0	0				
21	Painting	3/98	5,083	3	1,694	1,694	283	0	0				
22	Painting	6/98	5,415	3	1,805	1,805	752	0	0				
23	Painting	10/98	5,564	3	1,855	1,855	1,390	0	0				
24	Painting	12/98	1,513	3	504	504	463	0	0				
25	Total to pg 22, line 14		25,643		8,548	8,548	4,053	0	0	0	0	0	
26	painting>\$1,500 1999	7/99	11,752	3		1,959	3,917	3,917	1,959	0	0		
27	Total to pg 22, line 16		11,752			1,959	3,917	3,917	1,959	0	0	0	0
28	Climate Service Inc (repair HVAC)	1/00	1,703	3		568	568	568	0				
29	Climate Service Inc (repair HVAC)	1/00	1,970	3		657	657	657	0				
30	Capps Plumbing & Sewer (plumbing)	5/00	2,718	3		604	906	906	302	0			
31	GT Mechanical (repair HVAC)	7/00	1,898	3		316	633	633	316	0			
32	Capps Plumbing & Sewer (plumbing)	8/00	1,965	3		273	655	655	382	0			
33	Alden Bennett Construction (paint)	9/00	8,378	3		931	2,793	2,793	1,862	0			
34	Alden Bennett Construction (paint)	11/00	1,502	3		83	501	501	417	0			
35	painting>\$1,500 for 2000	7/00	8,333	3		1,389	2,778	2,778	1,389	0			
36	Total to pg 22, line 15		28,466			4,821	9,489	9,489	4,668	0	0	0	
37	Alden Bennett(paint/wallcover)	11/00	(1,502)	3			(501)	(501)	(501)	-1			
38	Capps(booster system)	1/01	2,705	3			902	902	902	0			
39	Coker(boiler)	4/01	3,879	3			970	1,293	1,293	323	0		
40	Total to pg 22, line 16		5,082		0	0	1,371	1,694	1,694	322	0	0	
41	GT Mechanical(tower pump)	5/02	1,374	3				305	458	458	153		
42	GT Mechanical(hvac repair)	5/02	2,617	3				582	872	872	291		
43	F.E Moran (smoke detection)	6/02	2,532	3				492	844	844	352		
44	Total to pg 22, line17		6,523		0	0	0	1,379	2,174	2,174	796	0	

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IL Healthcare Assoc. \$11504
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 31,652 Line 12-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ _____
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 43,473 Has any meal income been offset against related costs? no Indicate the amount. \$ n/a
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? _____
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.